MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

04595

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County. Anne Arundel
City or town. Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State. Maryland County. A. A.
City or town. Cheaseneld
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alexander Lamar Anderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife. Mary L. Anderson
6.(c) If alive, give age. years
7. Birth date of deceased (mo., day, yr.) Mar 28th 1879

8. AGE: Years	Months	Days	If less than one day
66	1	18	hrs. min.

9. Birthplace. A. A. Co Md.
(Town, county, and state)
10. Usual occupation. Farmer
11. Industry or business
FATHER 12. Name. Wm F. Anderson
13. Birthplace A. A. Co Md.
MOTHER 14. Maiden name. Victoria Starlings
15. Birthplace Maryland.
16. Informant. Mrs Alex Anderson
Address Chesapeake A. A. Co Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof. May 19-1945 (month) (day) (year)
Cemetery or crematory. Episcopalia
Location. Perryman Md.
18. Funeral director. John M. Taylor
Address Annapolis Md.
19. May 19th 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH. May 16 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1945, to May 16 1945
and that I last saw him alive on May 16 1945

	DURATION
Immediate cause of death. Acute Dilatation of Heart	May
Due to. Pulmonary edema	12
Due to. Bronchial Pneumonia.	
Duration. One weeks Quite	
Due to.	
Other conditions. Hypostatic Pneumonia	29 15

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE. George C. Bond M. D. or other
Address Annapolis Md. Date signed 5-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

BC T 04597

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Arnold.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days.
Hospital, Institution, or street address where death occurred: Magothy River.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1713 - East 25th Street.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frederick Wm. Baldwin

3.(b) Social Security Number 212-05-3551

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Sophia A. Koeckey
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): July 11 - 1892

8. AGE:

Years	Months	Days	If less than one day
52	10	24	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Furniture salesman.
11. Industry or business: At Sears Roebuck.

FATHER
12. Name: ? Henry T. Baldwin
13. Birthplace: ? Fair Haven Conn.

MOTHER
14. Maiden name: ? Rose Anna Bollos
15. Birthplace: ? Baltimore, Md.

16. Informant: Mrs. Sophia A. Baldwin
Address: 1713 - East 25th St. - Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 1945 (month) (day) (year)
Cemetery or crematory: Oaklawn Cemetery
Location: Baltimore County Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. June 4 1945 (Date rec'd by registrar) M. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—
and that I last saw h— alive on ——— 19—

Immediate cause of death	DURATION
Accidental Drowning in the Magothy River.	Sudden.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5/30/45
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Magothy River.
Means of injury: Drowning. Injured at work? No

23. SIGNATURE: Gustave H. Paulenbert M. D., or other
Address: Glen Burnie, Md. Date signed: 6/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUN 5 1985
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

BC T

0459828

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 18 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1034 Presstman Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BARNES - JOHN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Alverta Barnes, 1043 Presstman St., Balto 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE:

Years	Months	Days	If less than one day
63	unknown		---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Fred Barnes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-14-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.
Address

19. May 14 1945 E. T. Joyce Road Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1945, at 9:00A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 14, 1945 to May 2, 1945 and that I last saw him alive on May 2, 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	Known to us since 3/14/45
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis	Known to us since 3/14/45

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op. --------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of ------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work? --------

23. SIGNATURE: Fred V. Simmons M. D. or other

Address: Crownsville, Maryland Date signed 5/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

04599 P

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: a.a.

City or town: Brooklyn Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

~~Hospital, institution,~~ or street address where death occurred:

5707 Johnson St.

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: a.a.

City or town: Brooklyn Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5707 Johnson St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William A. Bohde

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Carrie Bohde

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 8th 1869

8. AGE: Years	Months	Days	If less than one day
76	3	14	..... hrs. ..... min.

9. Birthplace: Indiana (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER 12. Name: August Bohde

13. Birthplace: Germany

MOTHER 14. Maiden name: Custer (Unknown)

15. Birthplace: "

16. Informant: Mrs Fred Simon

Address: 5707 Johnson St. a.a.Co. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/23/45 (month) (day) (year)

Cemetery ~~or crematory~~: Lutheran

Location: New Haven Indiana

18. Funeral director: William Cook Inc

Address: 1217 St. Paul St

19. 5/23 (Date rec'd by registrar) 19 45 D.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 45 at 1 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 3 19 45 to May 22 19 45

and that I last saw him alive on May 20 19 45

Immediate cause of death	DURATION
Coronary thrombosis	
Due to: Hypertensive cardio vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of: .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P W Kessler MD M. D. or other

Address: 302 Palapico Ave Date signed: 5-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

04600

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel Co.
City or town near Severna Pk
(If outside city or towu limits, write RURAL aud give nearest town)
How long in above place of death?
Hospital, Inaiitution, or street addraaa where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A.Co.
City or towa near Severna Pk
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Clay Bourke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of huaband or wife Alice
6.(c) If alive, give age ..... yeara

7. Birth data of deceaaed (mo., day, yr.) March 27, 1859

8. AGE: Yeara	Months	Days	If less than one day
86			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Uaual occopstion Retired
11. Induatry or buaineaa
12. FATHER Name James McC. Bourke
13. FATHER Birthplace Maryland
14. MOTHER Maiden name Mary Lucas
15. MOTHER Birthplace Maryland
16. Informant Alma Brinatick
Addreaa near Severna PK.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/23/45 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Annapolis Blvd
18. Funeral director Md. Funeral Dirs., Inc., Earl Hess
Address 715 Light St.
19. 5/23/45 (Date rec'd by registrar) P.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/45 19..... at ..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19.45 to May 20 19.45
and that I last saw h.m alive on May 20 19.45

	DURATION
Immediate cause of death Hemorrhage from the Stomach	48 hours
Due to Carcinoma of the Liver & Stomach	6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death waa due to external cauaes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or towu) (County) (State)
Injured at home, farm, Induatry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James S. Billingsley M.D.
M. D. or other
Address Glen Burnie, Md. Date signed May 20, 1945

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-b)

CERTIFICATE OF DEATH

04601

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Linthicum Heights.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, institution, or street address where death occurred: 213 - Hammonds Ferry Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Linthicum Heights.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 - Hammonds Ferry Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James V. Bowers.

3.(b) Social Security Number: 212-14-2248A.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Wh.	W.	Married.

6.(b) Name of husband or wife: Ada A. Frizzell
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Aug. 6-1870

8. AGE:

Years	Months	Days	If less than one day
74	3	23	....hrs. ....min.

9. Birthplace: Westminster, Md. (Town, county, and state)
10. Usual occupation: Salesman.
11. Industry or business

FATHER
12. Name: John Bowers.
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Catherine Lindsay
15. Birthplace: Carroll County, Md.

16. Informant: Mrs. James V. Bowers (wife)
Address: Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31/45 (month) (day) (year)
Cemetery or crematory: Lorraine Pk.
Location: Woodlawn, Md.

18. Funeral director: Harry H. Wilkie
Address: 4101 Edmondson Ave

19. 5/29 19 45 H. W. Hedrick 5/29 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 19 45, at 12 10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 8 19 44 to 5/28/45 19 ....
and that I last saw him alive on 5/28/45 19 ....

	DURATION
Immediate cause of death: Heart failure	2 days.
Due to: Hypertension	One year.
Due to: Prostates	One year
Cystites	One year
Other conditions: Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Gustave A. Paulert M.D. M. D. or other
Address: Glen Burnie, Md. Date signed: 5/29/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

0402 P

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Point Pleasant, Brooklyn 25. -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel.
City or town: Brooklyn, 25 - R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Point Pleasant,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mary Bradley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married.

6.(b) Name of husband or wife: Frank Bradley
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): January 19 - 1866

8. AGE:

Years	Months	Days	If less than one day
79	3	13	...hrs. ...min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housekeeping.
11. Industry or business:

FATHER
12. Name: Georges Eisel
13. Birthplace: Germany

MOTHER
14. Maiden name: Christina Lohmeyer
15. Birthplace: Germany.

16. Informant: Mrs. Elzbeth Lenton
Address: 1316 - S. Konover St. - Baltimore.

17. Burial. Date thereof 5 - 7 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Glen Haven Cem.
Location: Glen Burnie Md.

18. Funeral director: Bernard C. Harle
Address: 121 E. West St. Annapolis

19. 5/3/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2nd 19 45 at 11 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 19 45 to May 2 19 45
and that I last saw her alive on 5/2/45 19
Immediate cause of death: Coronary occlusion — Duration: Sudden
Due to: Hypertension
Due to: Senility
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave A. Faubert M.D.
Address: Glen Burnie, Md. M. D. or other
Date signed 5/3/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Richardson

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

04603

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 30 Clay
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alverta V. Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: J. Jonas Brown

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Feb 12, 1875.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	3			

8. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER 12. Name: Daniel Brice

13. Birthplace: A. A. Co.

MOTHER 14. Maiden name: Martha Day

15. Birthplace: A.A.Co.

16. Informant: Jonas Brown
Address: Jonas Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15, 1945 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis Md.

18. Funeral director: J.R. Johnson

Address: Annapolis, Md.

19. May 15 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Only Dr. 19.., to May 12, 1945

and that I last saw h.. alive on May 12, 1945

Immediate cause of death	DURATION
Heart Failure	
Due to: Chronic Myocarditis	6 hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R.H. Richardson M.D.
M. D. or other

Address: Riverdale, Md. Date signed: 5/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

04604

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 yrs.

Hospital, institution, or street address where death occurred:
18 Lafyette Ave. Annapolis Md.

How long in hospital or institution? ****************

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Lafyette Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mammie Green Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Charles Brown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 10, 1883

8. AGE: Years	Months	Days	If less than one day
62	3	12	..... hrs. ..... min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: John Green
13. Birthplace: Prince George Co.

MOTHER
14. Maiden name: Caroline Gross
15. Birthplace: Prince George Co.

16. Informant: Charles Brown

Address: 18 Lafyette Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1945 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 NorthWest St. Annapolis Md.

19. May 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22, 1945 at 7:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1945, to May 22, 1945 and that I last saw h[illegible] alive on May 22, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	3 days
Due to, Chronic Nephritis	3 years
Due to,	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Richardson M.D.
M. D. or other

Address: Annapolis, Md. Date signed: 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

J4605

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a a

City or town: annapolis Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred: ~~[illegible]~~ Emergency Hospital

How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Annapolis Rural Harmans Creek
(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis R.F.D. 10
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Walter M. Bullen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Helen S. Bullen

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Oct 5 1894

8. AGE: Years	Months	Days	If less than one day
50	7	19	...hrs. ...min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Fletcher Bullen

13. Birthplace: maryland

MOTHER — 14. Maiden name: Lydia Banner

15. Birthplace: maryland

16. Informant: Helen S. Bullen

Address: annapolis R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27/45 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: annapolis - md

18. Funeral director: B. L. Hopkins

Address: annapolis. md

19. May 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1945, at 10 a5 P.M.

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination

and that I last attended deceased on May 24 1945

Immediate cause of death	DURATION
Fracture of neck	Sudden
Due to: Fracture of skull	Sudden
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 5/24/45

Where did injury occur? near Annapolis (City or town) A.C. (County) Md (State)

Injured at home, farm, industry, public place (where?): Defa Road

Means of injury: automobile Injured at work? No

23. SIGNATURE: John M Coffey MD Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Md Date signed: 5/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

T

04605 21

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

121 academy St

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 academy St

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME John Wesley Clark

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 23 - 1883

8. AGE:	Years	Months	Days	If less than one day
	61	7	26	..... hrs. ..... min.

9. Birthplace Annapolis, Md (Town, county, and state)

10. Usual occupation Retired

11. Industry or business U. S. Naval academy

FATHER 12. Name Daniel Clark

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant George Clark

Address 18 Gemas St annapolis

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 16/45 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director B L Hopkins

Address annapolis, Md

19. May 15 1945 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1216 1941 to 5 14 1945 and that I last saw him alive on 5 12 1945

Immediate cause of death	DURATION
coronary occlusion	1 hr (?)
Due to arteriosclerotic cardio-vascular disease	5 yrs.
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE S. Bowers M.D. M. D. or other

Address annapolis, Md Date signed 5/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 04607 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Cedar Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Cedar Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary M. Coates

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Leonard R. Coates
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec. 31, 1879
8. AGE: Years 65 | Months 4 | Days 4 | If less than one day ..... hrs. ..... min.
9. Birthplace: Davidsonville, A.A.Co, Md. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: George King
13. Birthplace: Germany

MOTHER
14. Maiden name: Junkmyer
15. Birthplace: unknown

16. Informant: Leonard R. Coates
Address: Cedar Park, A.A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Annapolis, Md.

18. Funeral director: William Gaesch & Sons
Address: Hyattsville, Md.

19. May 7 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1945 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to May 5 1945 and that I last saw h.. alive on May 1st 1945

	DURATION
Immediate cause of death: Generalized Carcinomatosis	
Primary, Carcinoma of left breast.	3 years
Due to: Duration 3 years. Surg. R.	
Due to:	
Other conditions: Left breast removed, in 1942.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Boyd, M. D. or other
Address: Annapolis Md. Date signed 5-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

64608

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County aa

City or town annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County aa

City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1014 Monroe St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME mary Ellen colburn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 21 — 1945

8. AGE: Years | Months | Days | If less than one day: 13 hrs. ..... min.

9. Birthplace annapolis, md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name David O. colburn
13. Birthplace annapolis md

MOTHER
14. Maiden name Margaret Hambrock
15. Birthplace annapolis, md.

16. Informant David O colburn
Address 1014 monroe st Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23/45 (month) (day) (year)

Cemetery or crematory St Mary's

Location annapolis md

18. Funeral director B. L. Hopkins

Address annapolis. Md

19. May 23 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mary Ellen Colburn May 22 19 45 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 19 45 to May 22 19 45, and that I last saw her alive on May 22 19 45

	DURATION
Immediate cause of death: Atelectasis	1 day
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boucl M. D. or other

Address Annapolis Md Date signed 5-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04609

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Mullberry Hill Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Mulberry Hill, Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Bertha A. Cook

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years: 34 | Months | Days | If less than one day: hrs. min.

9. Birthplace: A.A.Co.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Joseph Cook
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Elnora Cook
15. Birthplace: A.A.Co.

16. Informant: Elnora Cook
Address: Mulberry Hill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May, 15, 1945 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: Skidmore Md.

18. Funeral director: J.B.Johnson
Address: Annapolis, Md.

18. May 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2, 1945, to May 12, 1945 and that I last saw h... alive on May 12 1945

Immediate cause of death	DURATION
Carcinoma Fracture	-
Due to	
Due to Metal Stenosis	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Theodore T. Johnson M.D.
M. D. or other

Address: 35 Northwest St. Date signed 5/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04610 28

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years, 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 18 years, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 628 Bruce Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: COX - WILLIAM

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: ----------

6.(c) If alive, give age: -----

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years: 38 Months: unknown Days: If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Susie ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal, Which?) Date thereof: May 31, 1945 (month) (day) (year)
Cemetery or crematory: XXXXXXXXXX Mt. Auburn Balto. National
Location: Baltimore City

18. Funeral director: George G. Kelson
Address: 1303 Presstman St., Balto., Md.

19. 5/29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945 at 7:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1927 to May 26 1945 and that I last saw h... im ...alive on May 26 1945

	DURATION
Immediate cause of death: General Paresis	Known to us since 5/17/27
Due to: ----------	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Hubert J. Hinkwood M. D. or other
Address: Crownsville, Maryland Date signed: 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

T

04611

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? Six Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Mammie Curry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Curry

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1887.

8. AGE: Years	Months	Days	If less than one day
57	11	28	hrs. min.

9. Birthplace: Skidmore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: George Green
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Laura Green
15. Birthplace: A,A.Co.

16. Informant: William Curry
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25, 1945 (month) (day) (year)

Cemetery or crematory: Broadneck, Md.

Location: Broadneck, Md.

18. Funeral director: J.B.Johnson.

Address: Annapolis, Md.

19. May 26 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945, at 1.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1945 to May 23 1945 and that I last saw her alive on May 22 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Arteriosclerosis	?
Due to:	
Other conditions: Diabetes Mellitus (Include pregnancy within 3 months of death)	?

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. T. Kilmarx, Md
M. D. or other

Address: 31 Southgate Ave Date signed: 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

BC F 04612

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 11 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 7 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2109 Etting Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ----------

3.(a) FULL NAME: DORSEY - WILLIAM

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Ida Dorsey, 2109 Etting St., Balto., Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1873 ?

8. AGE: Years	Months	Days	If less than one day
72 ?	unknown	----- hrs.	----- min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: -------

FATHER 12. Name: John Hamilton Dorsey
13. Birthplace: Washington, D. C.

MOTHER 14. Maiden name: Mary ?
15. Birthplace: Washington, D. C.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: June 5, 1945 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Smith's Funeral Home
Address: 1125 19th St., Washington, D. C.

19. June 1 1945 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 45 at 7:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 19 44, to May 31 19 45 and that I last saw him alive on May 31 19 45

	DURATION
Immediate cause of death: General Arteriosclerosis	Known to us since 10/20/44
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis	Known to us since 10/20/44

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: -------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Hurl D. Humfreville M. D. or other
Address: Crownsville, Maryland Date signed: 5/31/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

05467 P

1. PLACE OF DEATH

County A. A. Registration Dist. No. 25

Village or City Broad Gn No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Frederick Sherman

(a) Residence: No. 412 Hilcrest Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W.	W.

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary Hoff.

6. DATE OF BIRTH (month, day, and year) 12/12/1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	5	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Gsr.

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME Philip

Gsr.

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Margaret ?

Gsr.

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Family.

(Address) 412 Hillcrest Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Schantz Date 5/9 1945

19. UNDERTAKER James P. McCleary

(Address) 430 E. Fort Ave.

20. FILED 5/8/45 C. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 7th - 7:00 Am

(Month) (Day) (Year) 1945

22. I HEREBY CERTIFY, That I attended deceased from April 18, 1945, to May 7, 1945

I last saw h.. alive on May 5, 1945; death is said to have occurred on the date stated above, at 7:00 A.M.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Myocardial Insufficiency	

Other **Contributory Causes** of importance:

Arteriosclerosis +	
Hypertension	

Name of operation Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? —

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

—

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John A. Schwentz M. D.

(Address) 1337 S. Charles St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

T 04613

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: U.S.N. Hosp. Annapolis, Maryland
How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 Jefferson St (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FAIRMAN, Charles G

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: (W) Lillian D. FAIRMAN
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): Sept 15 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	8	2		

9. Birthplace: Hillsdale Michigan (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER — 12. Name: Allen Fairman
13. Birthplace: Vermont
MOTHER — 14. Maiden name: Ela Spencer
15. Birthplace: Unknown
16. Informant: Lillian D Fairman
Address: 18 Jefferson St Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 45 (month) (day) (year)
Cemetery or crematory: National
Location: Annapolis
18. Funeral director: B L Hopkins
Address: Annapolis Md
19. May 18 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 19 45 at 9 15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 45 to May 17 19 45 and that I last saw him alive on 5-17 19 45

Immediate cause of death	DURATION
Thrombosis, Coronary Artery	2 Mo
Due to: coronary arteriosclerosis	5 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: Injured at work?

23. SIGNATURE: Rus Harris Lt Com (MC) USNR M. D. or other
Address: U.S.N. Hosp. Annapolis Md Date signed: 5-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

BC 04614

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 29 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 5 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1710 West Lafayette Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: FAUNTLEROY - ANITA FRANCES

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years	Months	Days	If less than one day
47	unknown		--- hrs. --- min.

9. Birthplace: Connecticut
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ---

FATHER
12. Name: Howard Fauntleroy
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret Howard
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 19, 1945 (month) (day) (year)
Cemetery or crematory: Arbutus
Location: Baltimore County

18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave., Balto., Md

19. May 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1944 to May 16 1945 and that I last saw her alive on May 16 1945

Immediate cause of death	DURATION
Chronic Myocarditis	6 mos.
Due to ---	
Due to ---	
Other conditions: Idiocy (Congenital) Known to us since 11/17/44	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert J. Brueckner M. D. or other
Address: Crownsville, Maryland Date signed: 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

64615

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a. a.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

13 Colonial ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a. a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Colonial ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel S. Fertitta

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Beulah V. Fertitta

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): March 25 1885

8. AGE: Years	Months	Days	If less than one day
60	1	27	....hrs. ....min.

9. Birthplace: Sicily (Town, county, and state)

10. Usual occupation: Shoe Repair

11. Industry or business

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Beulah V. Fertitta

Address: 13 Colonial ave Annapolis Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: May 26/45 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Annapolis. Md

19. Funeral director: B. L. Mapping

Address: Annapolis. Md.

19. May 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1945 to May 22 1945 and that I last saw h.. alive on May 22 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to:	
Due to:	
Other conditions: Coronary Insufficiency	5 months

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: George C. Bozel M. D. or other

Address: Annapolis Md Date signed: 5. 24. 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-b)

CERTIFICATE OF DEATH

P

04616

Reg. Dist. No. 25

1. PLACE OF DEATH:

County A A Co.

City or town Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A A Co.

City or town 531 Patrick Henry Drive

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ruth Emma Fitzpatrick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Allen F. Fitzpatrick

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) May 29 - 1912

8. AGE: Years	Months	Days	If less than one day
32	11		hrs. min.

9. Birthplace Balto City (Town, county, and state)

10. Usual occupation at Home

11. Industry or business

FATHER 12. Name Wm Iserlach

13. Birthplace Balto

MOTHER 14. Maiden name Sarah Wooden

15. Birthplace Balto

16. Informant Allen F. Fitzpatrick

Address 531 Patrick Henry Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28 (month) (day) (year)

Cemetery or crematory Mt Carmel Cem

Location City

18. Funeral director Leeds Funeral Home

Address 2008 Orleans St

19. May 25 19 45 A. W. Hedrick Registrar

(Date rec'd by registrar)

A.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 45, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19 45 to May 25 19 45 and that I last saw h[illegible] alive on May 25 19 45

Immediate cause of death	DURATION
Myocardial Insufficiency	Acute
Due to Septic Sore Throat	May 20/45
Due to	
Other conditions Severe infection Onset 3 weeks ago Refused Abortion (Include pregnancy within 3 months of death) the Mouth	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leon D. Hurley M. D.

M. D. or other

Address 4700 Kenmington Ave Date signed 5/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

04617

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town near Shore Acres Arnold
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 529 Lucerne Ave
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Mark Frisch

3.(b) Social Security Number 212-01-7826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife Lillian B Frisch
6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct 18. 1895

8. AGE:

Years	Months	Days	If less than one day
49	7	12	..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation manager
11. Industry or business Sears-Roebuck Co
FATHER 12. Name Benjamin Frisch
13. Birthplace Austria
MOTHER 14. Maiden name Ida Rudall
15. Birthplace Baltimore
16. Informant Mrs. Lillian Frisch
Address 529 N Luzerne Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 (month) (day) (year)
Cemetery or crematory Baltimore Cem
Location City
18. Funeral director Ullrich Funeral Home
Address 2008 Orleans St
19. June 11 1945 A. M. Hedrick per A E S
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30. 1945 at about 10 00 AM

21. I CERTIFY that death occurred on the date above stated. ~~that I attended deceased from~~ Post mortem Examination June 10 1945

	DURATION
Immediate cause of death Accidental Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of May 30 1945
Where did injury occur? near Arnold (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Magothy River
Means of injury Drowning Injured at work? No

23. SIGNATURE John M. Caffy M.D. Deputy Medical Examiner
Address Annapolis, Md Date signed 6/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133)

CERTIFICATE OF DEATH

T 04618

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Near Laurel Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Near Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. Fort Meade Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joshua Gaither

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 14 1903

8. AGE: Years	Months	Days	If less than one day
42	11	21	...hrs. ...min.

9. Birthplace Fort Meade Road Near Laurel
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Gaither

13. Birthplace Maryland

MOTHER 14. Maiden name Virginia Frankelen

15. Birthplace Millstone Md

16. Informant Rosie Parker

Address Laurel R.F.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8 1945 (month) (day) (year)

Cemetery or crematory Meadowbrook

Location Meadowbrook Md

18. Funeral director Ridgely Selby

Address 401 Main St Laurel Md

19. May 7 1945 (Date rec'd by registrar) Clara Hustead Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945, at 7 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to May 5 1945

and that I last saw h... alive on May 4 1945

Immediate cause of death Acute Dilatation Uremia Cystitis Pyelitis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D., or other

Address Date signed 5/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04619 Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havrede Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(Hospital, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME GALLOWAY - CHARLES

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	unknown

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ------ years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE:	Years	Months	Days	If less than one day
	75	unknown		-- hrs. --- min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/30/45 (month) (day) (year)
Cemetery or crematory: Harrell Grace md.
Location: Shipped to Pennington Funeral Home

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St Annapolis Md.

19. May 30 19 45 E F Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 19 45 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 12 19 45 to May 28 19 45 and that I last saw h--- alive on ---- 19 ----

Immediate cause of death	Chronic Myocarditis	DURATION: Known to us since 5/12/45
Due to	----------	
Due to	----------	
Other conditions	----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op. ------

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ------
Accident, suicide, or homicide: ---------- Date of ----
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ----

23. SIGNATURE: Albert V. Hinterweder M. D. or other
Address: Crownsville, Maryland Date signed 5/28/45

VS A15

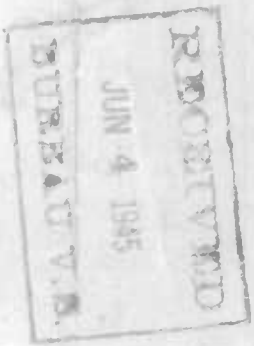
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9243

Galloway - Charles
Harford County
Admitted - May 12, 1945

Died - May 28, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04620

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Md. County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 E. Maple Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Isabelle Martin Rawlings Garey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Rex Robbins Garey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 23 - 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67	5	9		

9. Birthplace: Greensboro Md. Caroline County (Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business

FATHER
12. Name: Henry Cleveland Rawlings
13. Birthplace: Delaware

MOTHER
14. Maiden name: Ella Claudine Dilsaver
15. Birthplace: Sandalwood, Md.

16. Informant: Mrs. Ella Kelly
Address: Linthicum, Md.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: (month) May (day) 4 (year) 45
Cemetery or crematory: Greensboro
Location: Greensboro Md.

18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.

19. May 2 1945 (Date rec'd by registrar) Esther Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1935, to May 2 1945
and that I last saw h. alive on May 2 1945

Immediate cause of death	DURATION
Cardio-vascular Renal Disease	1 mo.
Due to: Arteriosclerosis	8 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Bare Jr. M.D.
M. D. or other
Address: Linthicum Date signed: 5-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of sex is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04621

FILM No. G 95 MAY 29 1945

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Edgewater, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 5 months

Hospital, institution, or street address where death occurred: Anne Arundel County Home.

How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: County:

City or town: Mc Kadett Texas (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Stephen Garrison

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male		

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 21 1868

8. AGE: Years	Months	Days	If less than one day
76	7	22	hrs. min.

8. Birthplace: Texas (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown [redacted]

15. Birthplace:

16. Informant: Mrs Wm H. Bucher

Address: Edgewater Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14. 1945 (month) (day) (year)

Cemetery or crematory: Anne Arundel Co Home

Location: Edgewater Md

18. Funeral director: H. E. Hardesty & Son

Address: Gaithersburg Md

19. May 14, 1945 (Date received by registrar) Edward Collinson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945, at 3 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 4 1945, to May 13 1945

and that I last saw h[illegible] alive on May 10 1945

Immediate cause of death	DURATION
Chr. Myocarditis	years.
Due to: Senility	
Due to:	
Other conditions: Senile Dementia	4 Mos+

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. J. Kleman MD M. D. or other

Address: 31 Southgate Ave Date signed: 5/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04622 P

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Pasadena

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Catalpha Road.

Stay in hospital or inst. (yrs., or mos., or days): ——

Stay in this community (yrs., or mos., or days): 8 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ——— County: ———

City or town: ——— Ward No. ———

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ———

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ———

3. (a) FULL NAME PAUL DAVID GAU

3. (b) Social Security Number 215-14-4543

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Malvina Landry Gau

6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1869.

8. AGE:	Years	Months	Days	If less than one day
	75	7		——— hrs. ——— min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired Marine Officer

11. Industry or business: Shipping

FATHER 12. Name: Henry Gau

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Matilda ———.

MOTHER 15. Birthplace: Germany

18. Informant: Mrs. Malvina Gau

Address: Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-14-45 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore

18. Funeral director: Leonard J. Ruck

Address: 5305 Harford Road

19. May 12 1945 (Date rec'd by registrar) A. W. Yetrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10/45 19——, at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1945, to date 19——,

and that I last saw him alive on 5/9/45 19——,

Immediate cause of death: Coronary Occlusion — DURATION 2 weeks

Due to: ———

Due to: ———

Other conditions: ———

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ———

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of ———

Where did injury occur? ——— (City or town) ——— (County) ——— (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work?

23. SIGNATURE Harry M. Moore M. D. or other

Address: Glen Burnie, Md. Date signed 5/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 04623

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Washington

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gordon, Larby (Gordon)

3.(b) Social Security Number:

4. Sex: M. | 5. Color or race: B. | 6.(a) Single, Married, widowed, or divorced: unknown

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1884?

8. AGE: Years: 61? | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER 12. Name: unknown

13. Birthplace:

MOTHER 14. Maiden name: unknown

15. Birthplace:

16. Informant: Hospital records

Address: Crownsville

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 6/2/45 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cemetery

Location: Balto. Md.

18. Funeral director: William A. Jackson

Address: 916 Penna Ave

19. May 30 19 45 (Date rec'd by registrar) E.T. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1945 to May 30 1945

and that I last saw him alive on May 30 1945

Immediate cause of death: Pulm. tuberculosis — DURATION: prev. to admiss

Due to:

Due to:

Other conditions: Liver, gen. arteriosclerosis prev. to admiss

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert S. Smallwood M. D. or other

Address: Crownsville Date signed: 5-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BC-1 04624

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 26 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ----------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: GRANT - LONNIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ----------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): April 4, 1906

8. AGE:	Years	Months	Days	If less than one day
	39	1	13	---- hrs. ---- min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER
12. Name: Charles Grant
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Loisial ?
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal (Which?): Burial Date thereof: 5-31-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt.
Address:

19. (Date rec'd by registrar): May 31 19 45 E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 19 45 at 5:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 19 45 to May 17 19 45 and that I last saw him alive on May 17 19 45

Immediate cause of death	DURATION
Lung Tuberculosis	Apprx. 6½ mos.
Due to: ----------	
Due to: ----------	
Other conditions: Mental Deficiency Without Psychosis (Include pregnancy within 3 months of death)	Known to us since 3/21/45

Major findings of operations: ----------
Date of op.: ------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ----------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 5/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

VBC P

04625

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 14 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1003 North Parrish Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: HAMILTON * ERNEST

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	separated

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): December 12, 1900

8. AGE:	Years	Months	Days	If less than one day
	44	4	24	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Furniture

FATHER 12. Name: unknown

FATHER 13. Birthplace: unknown

MOTHER 14. Maiden name: Emma Johnson

MOTHER 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: May 10, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: George G. Kelson

Address: 1303 Presstman St., Balto., Md.

19. 5/9/45 (Date rec'd by registrar) Outland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1945, at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22, 1944, to May 6, 1945, and that I last saw him alive on May 6, 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 12/22/44
Due to: ----------	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------

Date of op.: ---------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ------- Injured at work? -----

23. SIGNATURE: Albert J. Montrowe M. D. or other

Address: Crownsville, Maryland Date signed: 5/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dunker. Md
Frank Watkins
12/24/49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

04626 P

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County Anne Arundel
City or town Odenton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Odenton,
(If outside city or town limits, write RURAL and give nearest town)
Street No. Telegraph Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard S. Hannon.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Nettie M Hannon.
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1879

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace Va (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Unemployed

FATHER
12. Name Sherd Hannon
13. Birthplace Va.

MOTHER
14. Maiden name Christina Harlow
15. Birthplace Va.

16. Informant Rose L. Harding.
Address 2717 Miles Ave.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof May 8, 1945 (month) (day) (year)
Cemetery or crematory Methodist Cem.
Location Shenandoah Va.
18. Funeral director Chenoweth & Donovan.
Address 3615-17 Chestnut Ave.

19. 5-8-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6-45, 19, at 10 45 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 11-44, 19, to May 6-45, 19, and that I last saw h alive on May 4-45, 19.

Immediate cause of death	DURATION
Acute Cardiac Failure	1 day.
Due to	
Carcinoma Rectum	5 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or other
Address Glenburnie Md Date signed May 6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

T04627

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Illinois County: --
City or town: Eldorado
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt #2 Box 130 A
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: John L. HARDIN 36,961,358

3.(b) Social Security Number: --

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Barbara Jean Hardin
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Jan 28 1926

8. AGE: Years	Months	Days	If less than one day
19	3	19	..... hrs. ..... min.

9. Birthplace: Wassnon, Ill.
(Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: John W. Hardin
13. Birthplace: unknown

MOTHER
14. Maiden name: Ellen Adeline (unknown) Hardin
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 17 1945 (month) (day) (year)
Cemetery or crematory: Rance Martin Funeral Home
Location: Eldorado, Illinois

18. Funeral director: Howard N. Blight Jr. HOWARD N. BLIGHT, Jr.
Address: 4914 Belair Rd. Baltimore Md.

19. 17 May 1945 (Date rec'd by registrar) W. J. Lawson Jr. W. J. LAWSON JR. Registrar
1st Lt. MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 May 1945 at 6:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 May 1945, to 16 May 1945 and that I last saw him alive on 16 May 1945

Immediate cause of death	DURATION
Hemorrhage	
Due to: Wounds of Abd., back - Left arm & left leg	3 hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: Confirmed as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6 May 45
Where did injury occur? Ft. Geo G Meade (City or town), Anne Arundel (County), Md. (State)
Injured at home, farm, industry, public place (where?): Firing Range
Means of injury: Bazooka Explosion Injured at work? Yes

23. SIGNATURE: Myron R. Zbudowski
MYRON R. ZBUDOWSKI, Capt. M. D. or other MC
Address: Regional Hosp., Ft Meade, Md. Date signed: May 17, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04628

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1950)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo
Hospital, institution, or street address where death occurred:
Firing Range
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County: -
City or town: Toledo
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1015 Marmion Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: Charles E. HARVEY

3.(b) Social Security Number: 20,504,151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred L. Harvey
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 2 Oct 1914

8. AGE: Years	Months	Days	If less than one day
30	7	15	- hrs. - min.

9. Birthplace: Toledo, Ohio (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U.S.Army
12. FATHER — Name: Frank H. Harvey
13. FATHER — Birthplace: Unknown
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: Unknown
16. Informant: Service Record
Address: U.S.Army
17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 18 1945 (month) (day) (year)
Cemetery or crematory: Ira Garner Funeral Home
Location: 2211 Lawrence St., Toledo, Ohio
18. Funeral director: Howard M. Blight Jr. HOWARD M. BLIGHT, Jr.
Address: 4914 Belair Rd., Baltimore, Md.
19. 17 May 19 45 (Date rec'd by registrar) W.J.LAWSON, JR., Registrar
W. J. Lawson Jr. 1st Lt., MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 May 19 45 at 1600 M

21. I CERTIFY that death occurred on the date above stated: that I ~~attended deceased from~~ viewed deceased ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ ~~last attended xxxxxx~~ on 16 May 19 45

Immediate cause of death	DURATION
Wound, perforating, skull with maceration of brain.	
Wound, perforating of thorax with ~~xxx~~ laceration of heart.	
Wound, perforating, left supra-~~xxx~~ clavicular with laceration of left subclavian artery.	
~~Due to (b)~~ Multiple lacerations and fracture of left humerus & femur	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: Confirmed as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 16 May 45
Where did injury occur? Ft Geo G Meade, (City or town) Anne Arundel, (County) Md (State)
Injured at home, farm, industry, public place (where?): Firing Range
Means of injury: Bazooka Explosion Injured at work? Yes

23. SIGNATURE: [signature] M. D. or other
Address: Regional Hosp., Ft Meade, Md. Date signed: 17 May 45

M

VS A1 (1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 046298

Reg. Dist. No. .....

1. PLACE OF DEATH: A. A.
County Crownsville
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9½ hours
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 9½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Balto.
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 135 Winters Ave (If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME Edward Hawkins
3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C.	single

6.(b) Name of husband or wife /
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 8, 1904

8. AGE: Years 40 | Months 10 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Richard Hawkins Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Richard Hawkins
13. Birthplace Md
MOTHER 14. Maiden name Mary Hawdley
15. Birthplace Md
16. Informant Hospital Records
Address Crownsville, Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory BURIAL 5/18/45
Location OELLA Howard Co.
18. Funeral director JOHN PHILIP HARTUNG
Address 918 DR. H. Hill DRIVE
19. 5/14/45 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945, at 7-A. M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination
~~and that I last saw him alive on~~ May 13, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Less than 1 day
Due to Syphilis	years
Epilepsy	years
Due to Chronic alcoholism	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? Halstead (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE John M. Caffy Deputy medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 5/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. West

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-4)

CERTIFICATE OF DEATH

1

04630 2c

Reg. Diat. No.....

1. PLACE OF DEATH:

County..... ~~Sally Henson~~ Anne Arundel

City or town..... Lothian Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoce of mother)

State..... Md. County..... A. A.

City or town..... Lothian, Annapolis, Md.

(If outside city of town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Sally Henson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husbend or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Unknown 1885

8. AGE: Yeare	Months	Days	If less than one day
? 60			..... hrs. ..... min.

9. Birthplace A. A. CO.

(Town, conoty, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Malden name Unknown

15. Birthplace

16. Informant Clinton Wallace

Address 25 College Ave.

17. Burial Date thereof May 16, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Lothian, Md.

18. Funeral director J. B. Johnson

Address Annapolis, Md.

19. May 15 1945 W. P. Taylor Dep'y Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 8:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to May 13 1945 and that I last saw h.. alive on May 7, 1945

Immediate cause of death	DURATION
(a) Chronic Myocarditis	7
(b) Chronic Nephritis	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE T. B. West M. D. or other

Address Lothian Date signed 5/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

(T)

VS A15

T 04631

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

VS A15 (1) (A) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Geo. G. Meade,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
Firing range
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Illinois County: -
City or town: Elizabethtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RFD #1
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: James P. HOLBROOK ASN 36928419

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If ever, give age: - years

7. Birth date of deceased (mo., day, yr.): October 21, 1926

8. AGE: Years	Months	Days	If less than one day
18	6	28	- hrs. - min.

9. Birthplace: Elizabethtown, Illinois
(Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Lloyd Holbrook
13. Birthplace: Unknown

MOTHER
14. Maiden name: Cabbie (unknown) Holbrook
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 20. 1945 (month) (day) (year)
Cemetery or crematory: J. L. Dorsick Funeral Home
Location: Harrisburg, Illinois
18. Funeral director: Howard F. Blight Jr.
Address: 4914 Belair Road, Baltimore, Md.

19. May 19, 1945 (Date rec'd by registrar) W. J. Lawson Jr. W.J. LAWSON, JR., 1st Lt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1945 at 1600 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Wound, perforating left chest, left lung, left bronchus, aorta, right upper lobe of lung.	
Hemorrhage, acute, severe, exsanguinating with hemothorax.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op. -
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: May 18, 1945
Where did injury occur? Ft. Meade, Anne Arundel, Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Firing range
Means of injury: Grenade Injured at work? Yes

23. SIGNATURE: Frederick W. Neil Capt MC M. D. or other
Address: Reg Hosp Ft Meade Md Date signed: May 19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

1 04632

Reg. Dist. No. 20.

1. PLACE OF DEATH:
County a a
City or town Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a a
City or town Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Agnes Hopkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	married

6.(b) Name of husband or wife Samuel M. Hopkins
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 7 - 1880

8. AGE: Years	Months	Days	If less than one day
65	1	18	hrs. min.

9. Birthplace Bladensburg Md.
(Town, county and state)
10. Usual occupation House wife
11. Industry or business
FATHER 12. Name John T. Fawcett
13. Birthplace Maryland
MOTHER 14. Maiden name Margaret Jones
15. Birthplace Maryland
16. Informant Samuel M. Hopkins
Address Davidsonville. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28/45 (month) (day) (year)
Cemetery or crematory M. E. cemetery
Location Davidsonville Md.
18. Funeral director B. L. Hopkins
Address Annapolis. Md.
19. May 27 19 45 Carrie J. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 45 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination
~~and that I last saw him alive on~~ May 25 19 45

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to Chronic Endocarditis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Caffey M.D., Deputy Medical Examiner
M. D. or other
Address Annapolis Md. Date signed 5/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC J 04633

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs., 6 mos., 2 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 21 yrs, 6 mos, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3. (a) FULL NAME: HUNDLEY - WILLIAM

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): January 9, 1888

8. AGE: Years	Months	Days	If less than one day
57	3	22	--- hrs. --- min.

9. Birthplace: Alabama
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Josephine Hundley
15. Birthplace: Alabama

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/44 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address

19. (Date rec'd by registrar) May 14 1945 — E. T. Joyce Love Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1945 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 1923 to May 1 1945 and that I last saw h... Im... alive on May 1 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to: ---	
Due to: ---	
Other conditions: Schizophrenia	Known to us since 1923

(Include pregnancy within 3 months of death)

Major findings of operation: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Wm. T. Woods M. D. or other

Address: Crownsville, Maryland Date signed: 5/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04634

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: Chester G. HYLE

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude G. Hyle
6.(c) If alive, give age: -
7. Birth date of deceased (mo., day, yr.): Dec 12 1894

8. AGE: Years	Months	Days	If less than one day
50	5	13	- hrs. - min.

9. Birthplace: Faulk, S. D. (Town, county, and state)
10. Usual occupation: Post Exchange Manager
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Post Exchange Personnel Records
Address: Ft. Geo. G. Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 25, 1945. (month) (day) (year)
Cemetery or crematory: Davidsonville M.E. Church
Location: Davidsonville, Md.

18. Funeral director: Ritchie Bros. J. Seth Ritchie
Address: Upper Marlboro, Md.

19. May 25, 1945 W. J. Lawson Jr.
(Date rec'd by registrar) W.J.LAWSON,JR., 1st Lt. (Registrar)
MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ~~XX~~ on ~~X~~ ~~X~~ May 25, 1945
and that I last saw him alive on May 25, 1945

Immediate cause of death	DURATION
Hemorrhage, cerebral	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. -
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - Injured at work? -

23. SIGNATURE: Walter B. Buck
Walter B. Buck, Capt., MC. M. D. or other
Address: Reg Hosp Ft Meade Md Date signed: May 25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

04635

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Conduit Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Alfred Jacobsen

3. (b) Social Security Number

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Edith Way Jacobsen
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan. 4, 1882
8. AGE: Years 63 | Months 3 | Days — | If less than one day ..... hrs. ..... min.
8. Birthplace: Annapolis Md (Town, county, and state)
10. Usual occupation: carpenter, ret.
11. Industry or business: U.S. Naval Academy
FATHER 12. Name: Jacob Jacobsen
13. Birthplace: Norway
MOTHER 14. Maiden name: Margaret A Gannon
15. Birthplace: Scotland
16. Informant: Edith Way Jacobsen
Address 117 Conduit St, Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1945 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore, Md
18. Funeral director: John W. Taylor
Address: Annapolis, Md
19. May 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1945, at 9 10P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 30 1945, to May 4 1945
and that I last saw h[illegible] alive on May 1 1945

	DURATION
Immediate cause of death: Cardiac Vascular Failure	Instantaneous
Due to: Coronary Occlusion	Several days
Due to: Diabetes Mellitus	Several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Allen Purvis, M. D. or other
Address: Annapolis Md Date signed 5/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04636

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
Street No. unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: JOHNSON - LANGSTON

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Ettal (?) Johnson
St. Michaels, Md. 6.(c) If alive, give age: unk. years
7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years	Months	Days	If less than one day
38	unknown		--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Cannery

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 23, 1945 (month) (day) (year)
Cemetery or crematory: St. Michaels, colored
Location: St. Michaels, Talbot County
18. Funeral director: J. Norman Marshall
Address: St. Michaels, Maryland

19. 5/22 1945 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1945 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 20 1945 to May 20 1945 and that I last saw him alive on May 20 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 4/3/45
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 5/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

T04637

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Ann Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Fleet
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife Mariah Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	27	hrs. ..... min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Pauline Johnson

Address 42 Fleet St. Annapolis, Md.

17. Burial Date thereof May 20, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md.

19. May 19 1945 W. Branch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 3 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15 1944, to May 15, 1945 and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Malignant Hypertension	1 mo
Due to Hypertension	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore H. Johnson M. D. or other

Address 35 Northwest Blvd Date signed 5/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04638

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1044 North Eden Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: JONES - RICHARD

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Agnes Jones

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
45	unknown		-- hrs. ----- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Edward Jones
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mattie Dixon
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. 5/7/45 Buried (Burial, cremation, or removal. Which?) Date thereof 5/10/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary cem.

Location: Anne Arundel County

18. Funeral director: Byron + Mamie Wright

Address: 721 Cresmith St. Balto. Md.

19. 5-9-45 (Date rec'd by registrar) 19 45 ---------- Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 45 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 19 45 to May 5 19 45 and that I last saw him alive on May 5 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: ----------	
Due to: ----------	
Other conditions: Alcoholic Psychosis	Known t
Korsakow's Psychosis	us since
(Include pregnancy within 3 months of death)	4/14/45

Major findings of operations: ----------

Date of op. -------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Herbert J. Stoltzfus M. D. or other

Address: Crownsville, Maryland Date signed: 5/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

T

04639

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Point Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A A
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #9
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Howard Jones

3.(b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Rose
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 10, 1872
8. AGE: Years 72 Months Days If less than one day hrs. min.
9. Birthplace Bladensburg Md.
(Town, county, and state)
10. Usual occupation Railroad [illegible]
11. Industry or business Ret.
FATHER 12. Name unknown
13. Birthplace unknown
MOTHER 14. Maiden name Mary B. Walker
15. Birthplace unknown
16. Informant Saddie A. Bland
Address Point Pleasant, Anne Arundel Co
17. Removal Date thereof May 4 1945 Md.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Harold Saltmall
Location 436-7th St S.W. Wash. D.C.
18. Funeral director Harold Saltmall
Address 436-7th St. S.W. Washington D.C.
19. May 4 1945 [illegible] Dep. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 - 45 19 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 - 43 19 to May 4 - 45 19
and that I last saw him alive on May 3 - 45 19

Immediate cause of death	DURATION
Lobar Pneumonia	1 day
Due to	
Due to	
Other conditions Malignant Hypertension Cardio vascular Disease	4 years

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D., or other
Address Odenton Md. May 4 - 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

T

04640

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Patuxent Road (near Ward Chapel)

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Odenton, R.F.D. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Patuxent Road - Between Odenton & Patuxent.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Eugene Felix King

3. (b) Social Security Number: 218-14-3181

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife: Lavie King (Nee Clements) 6(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1884.

8. AGE:

Years	Months	Days	If less than one day
61	4	21	____ hrs. ____ min.

9. Birthplace: Halifax, Va. (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER 12. Name: John King

13. Birthplace: Virginia

MOTHER 14. Maiden name: Lord Freeman

15. Birthplace: Virginia

16. Informant: Mrs. Eugene King

Address: Odenton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28, 1945 (month) (day) (year)

Cemetery or crematory: Glen Haven Cem.

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. May 27 1945 (Date rec'd by registrar) Mrs. Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1944 to 5/25/45 and that I last saw him alive on 5/20/45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day.
Due to arteriosclerosis	1 year.
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations:

Ot autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry M. Moore M.D. M. D. or other

Address: Glen Burnie Md. Date signed: 5/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

T 04641

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Albert Lee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Eliza Lee
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Apr 25, 1878

8. AGE: Years	Months	Days	If less than one day
67	1	1	hrs. min.

9. Birthplace: Shady Side (Town, county, and state) Md
10. Usual occupation:
11. Industry or business

FATHER
12. Name: John Lee
13. Birthplace: Va

MOTHER
14. Maiden name: Susan Cruteltby
15. Birthplace: Shady Side - A.A. Co. Md

16. Informant: Mrs Elayne Rogers
Address: Shady Side

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28-45 (month) (day) (year)
Cemetery or crematory: Woodfield Cem.
Location: Galesville Md

18. Funeral director: W.C. Standerty & Son
Address: Galesville Md

19. May 27 1945 (Date received by registrar) J.B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26, 1945, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to May 26 1945
and that I last saw h.. alive on May 26 1945

Immediate cause of death	DURATION
Acute Myeloblastic Leukemia	8 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Bozeuch Md
M. D. or other
Address: Annapolis Md Date signed: 5/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04642

21

Reg. Diat. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Pinehurst

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Pinehurst on the Bay

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MADELEINE C. MACMILLAN

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1896

8. AGE: Years	Months	Days	If less than one day
48	5	18	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: J. Edward Cusby

13. Birthplace: Md.

MOTHER 14. Maiden name: Margaret Barson

15. Birthplace: Md.

16. Informant: Wm. D. Macmillan

Address: Pinehurst, P. O. Pasadena, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-12-45 (month) (day) (year)

Cemetery or crematory: New Cathedral cemetery

Location: Balto., Md.

18. Funeral director: H. H. Witzke

Address: 4101 Edmondson ave., Balto., Md.

19. V-10- 19 45 (Date rec'd by registrar) L. A. Preis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 19 45, at 4 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 44, to 5-10-45 19

and that I last saw her alive on 5-9-45 19

Immediate cause of death	DURATION
Acute Pancreatitis	4 hrs
Due to	
Due to	
Other conditions: Cerebral hemorrhage	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. A. Preis M. D.

Address: Pasadena, Md. M. D. or other

Date signed V-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

CERTIFICATE OF DEATH

04643

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Shady Side, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Shady Side, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Alonza Mathews

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Eliza Mathews

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1870

8. AGE: Years	Months	Days	If less than one day
75	3	14	..... hrs. ..... min.

9. Birthplace: Shady Side
(Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER 12. Name: Henry Mathews

FATHER 13. Birthplace: A.A.Co.

MOTHER 14. Maiden name: Rachiel Scott

MOTHER 15. Birthplace: A.A.Co.

16. Informant: Walter Mathews

Address: Shady Side, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24, 1945 (Month) (day) (year)

Cemetery or crematory: St. Mathews

Location: Shady Side, Md.

18. Funeral director: J.B.Johnson

Address: Annapolis, Md.

19. May 24 19 45 (Date rec'd by registrar) W. J. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 19 45 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44 to May 24 19 45

and that I last saw h... alive on May 24 19 45

Immediate cause of death	DURATION
Uremic Coma	2 Days.
Due to Chronic Nephritis	1 year
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exterenal causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

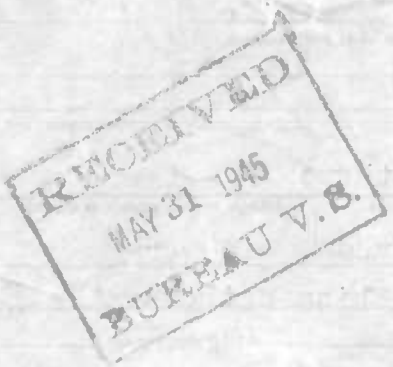
23. SIGNATURE: R. F. Richardson M.D.
M. D. or other

Address: Annapolis, Md. Date signed 5/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
MAY 31 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

(74644)

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 69 Amos Garrett Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice Amelia McCoy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 15th 1864

8. AGE: Years 80 | Months 8 | Days — | If less than one day ____ hrs. ____ min.

9. Birthplace: Bernerville N.J.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Joseph H. J. McCoy
13. Birthplace: N. J.

MOTHER
14. Maiden name: Mary Cole
15. Birthplace: N. J.

16. Informant: Mrs. Ortha McCoy Klein
Address: 69 Amos Garrett Blvd. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17th 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn
Location: Baltimore

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. May 17 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945 at 2:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1942 to May 15 1945 and that I last saw h[illegible] alive on May 15 1945

Immediate cause of death	DURATION
acute dilatation of heart	1 hr
Due to chronic myocarditis	4 yrs
Due to arteriosclerotic cardio-vascular disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. Bozzuchi MD
M. D. or other
Address: Annapolis Md Date signed 5/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 04645

Reg. Dist. No. 22

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: P. G. Co.
City or town: Laurel Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P.G. Co.
City or town: Laurel Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillie May McDonough

3. (b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Thomas McDonough
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 4, 1883
8. AGE: Years: 62 Months: 10 Days: 14 If less than one day: hrs. min.
9. Birthplace: Leesburg Va (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Columbus Beach
13. Birthplace: Leesburg Va
MOTHER 14. Maiden name: Sarah Mathis
15. Birthplace: Leesburg Va
16. Informant: Wm McDonough Husband
Address: 1236 - 39th N.W. Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: Washington D.C.
18. Funeral director: Gawler Funeral Home
Address: Laurel Md.
19. May 19 1945 (Date rec'd by registrar) Clara Hardesty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945 at 5-30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 7 1945 to May 18 1945
and that I last saw h.. alive on May 18 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	12 Days
Due to: Nephritis	5 Yrs
Due to: Arteriosclerosis	15 Yrs
Other conditions: Hemiplegia	10 Yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. M. Darcey M.D. M. D. or other
Address: Laurel Md. Date signed: 5/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

04646

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 63 Clay St Annapolis Md.
How long in hospital or institution? ******************

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 63 Clay St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ************

3. (a) FULL NAME: Carrie McGowan

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: ******************

6.(c) If alive, give age: **** years

7. Birth date of deceased (mo., day, yr.): May 18, 1887

8. AGE: Years	Months	Days	If less than one day
58 58		7	hrs. min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: John McGowan
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: Anne Arundel Co. Md.

16. Informant: Emma V. Coates
Address: 63 Clay St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/ 29/ 45 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: Smithville, Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. May 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21, 1945, to May 25, 1945 and that I last saw h..ve alive on May 25, 1945

Immediate cause of death	DURATION
Sarcoma of left Leg	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. R. E. Rudolph M. D. or other
Address: Annapolis, Md. Date signed 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

04647

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town ~~Near~~ Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Ward our
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas William Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ethel May Miller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	6	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual occupation clerk
11. Industry or business Chesapeake Seafood Co.
FATHER 12. Name Henry F. Miller
13. Birthplace Washington, D.C.
MOTHER 14. Maiden name Martha E. Busch
15. Birthplace N.C.
16. Informant Mrs. Ethel May Miller
Address Conduit St, Annapolis, Md
17. Burial Date thereof May 31 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.
18. Funeral director John W. Taylor
Address Annapolis, Md
19. May 31 19 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 45 at 10 30 p. M
21. I CERTIFY that death occurred on the date above stated; that I last attended deceased from ~~.....~~ Postmortem Examination 19 ..... to ~~.....~~ May 25 19 45

	DURATION
Immediate cause of death	
Coronary Embolism	Sudden
Due to Coronary sclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M Claffy M.D. Deputy Medical Examiner
M.D. or other
Address Annapolis, Md Date signed 5/30/45

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (M) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

04648 21
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred: 95 Cathedral St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a. e.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 95 Cathedral St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Juliet O Myers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	Widow

6.(b) Name of husband or wife: Henry B. Myers

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10 — 1860

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	2			

9. Birthplace: Annapolis. md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: David S. myers

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Eliza Vinsanderfer

15. Birthplace: Unknown

16. Informant: Frank Small

Address: 95 Cathedral St Annapolis, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: may 13/45 (month) (day) (year)

Cemetery or crematory: St Anne's

Location: Annapolis md

18. Funeral director: B L Hopkins

Address: Annapolis. md

19. May 12 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1945, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1945, to May 10, 1945

and that I last saw h... alive on May 10, 1945

Immediate cause of death	DURATION
Senility	2 yrs.
Due to Arteriosclerosis. Cor. & R.	
Duration: 20 years.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other

Address: Annapolis, Md Date signed: 5/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

T4649

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:
Drowned in Chesapeake bay off Naval Academy

How long in hospital or institution? ***************

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Marbyland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 Pleasant Court
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Randolph Columbus Parker

3.(b) Social Security Number: 214-05-1466

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs Margeret Alverta Parker

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): August 28, 1911

8. AGE: Years	Months	Days	If less than one day
33	9		....hrs. ....min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Edward Lewis Parker
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Mrs Carrie McGowan
15. Birthplace: Annapolis Md.

16. Informant: Mrs Margeret Parker

Address: 2 Pleasant Court Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/ 28/45 (month) (day) (year)

Cemetery or crematory: Bour Hill Cemetery

Location: West st extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. May 25 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 45 at about 9 32 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination to May 25 19 45 ~~and that I last saw h... alive on~~

Immediate cause of death	DURATION
Drowning	
Due to: Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5/25/45

Where did injury occur? near Annapolis (City or town) A. A. (County) Mary Land (State)

Injured at home, farm, industry, public place (where?) Annapolis Yacht Basin

Means of injury: Tractor plunged into ... Injured at work? Yes

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or Coroner

Address: Annapolis Md. Date signed 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (196)

CERTIFICATE OF DEATH

P4650

Reg. Dist. No. 27

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 21 days

Hospital, institution, or street address where death occurred:
Regional Hospital

How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County: Unknown

City or town: Daytona Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 Vermont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Donald F. PHILLIPS

3.(b) Social Security Number: 13,141,180

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 28, 1925

8. AGE: Years	Months	Days	If less than one day
19	11	-	— hrs. — min.

9. Birthplace: Marblehead, Mass.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Charles F. Phillips
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mrs. Ruth (unknown) Phillips
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)

Cemetery or crematory: Baggett-Weathersby & McIntosh

Location: N. Beach St., Daytona Beach, Fla.

18. Funeral director: HOWARD BLIGHT, JR

Address: 4914 Belair Rd. Baltimore, Md.

19. 29 May 1945 (Date rec'd by registrar) W. J. Lawson Jr. Registrar
W.J. LAWSON, JR., 1st Lt., MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 May 1945, at 5:38 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased ~~SIX~~ on 28 May 1945 ~~X~~, ~~X~~, ~~X~~ and that I last saw him alive on 28 May 1945

Immediate cause of death: Pulmonary embolism — DURATION: Sudden

Due to: Thrombophlebitis, rt. leg — 1 mo 11da

Due to: Wound, penetrating, lower left quadrant of abdomen with perforation of urinary bladder, — 18 Apr. 45

Other conditions: Explosion of hand gren ada, on combat range, Cpl. Co.
(Include pregnancy within 3 months of death)

Major findings of operations: Perforation of urinary bladder

Date of op. 18 Apr. '45

Autopsy results: Confirmed as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Combat training accident. Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: S. D. Hoeper
S. D. HOEPER, 1st Lt., MAC M. D. or other

Address: Regional Hosp Ft. Meade, Md. Date signed 29 May 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

+ 04651

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State Maryland County Anne Arundel

City or town Arnold Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Addrenne Pluppo

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Jefferson Pluppo

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12th 1863

8. AGE: Years	Months	Days	If less than one day
82	7	—	hrs. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Jefferson Pluppo

Address Arnold A.A.Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 1945 (month) (day) (year)

Cemetery or crematory Asbury

Location Arnold A.A.Co. Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. May 14 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1945, to May 12 1945, and that I last saw h alive on May 12 1945

Immediate cause of death	DURATION
Chr. Myocarditis	7
Due to	
Due to	
Other conditions: Simple catarrhal fever (Include pregnancy within 3 months of death)	5 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Klevans, Md
M. D. or other

Address 31 Southgate Ave Date signed 5/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (131-a)

Registered No. 04652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) ~~Baltimore City~~ Maryland Anne Arundel Co.

(b) Street address Furnace Branch Md

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in ~~Baltimore~~ Anne Arundel (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Furnace Branch
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carrie Pumell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife James Pumell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown appox 1877

8. AGE: Years	Months	Days	If less than one day
appox 68			hr. min.

9. Birthplace Germantown Pa.
(Town, county, and state)

10. Usual Occupation domestic

11. Industry or business —

FATHER 12. Name Joseph Brumbley

13. Birthplace Pa.

MOTHER 14. Maiden Name Clementine — Unknown

15. Birthplace Pa.

16 (a) Informant Leonard Pratt (Son)

(b) Address Furnace Branch Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co. Md

18 (a) Funeral director Chas. H. Alexander

(b) Address 927 W. Monument St.

19 (a) 5-22-45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 45, at 10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 44 to May 21 1945, and that I last saw h[illegible] alive on May 19 19 45.

Immediate cause of death	Duration
Chronic Pancreatitis	
Nephritis (uremia)	
Due to	
Due to	
Other Conditions Myocarditis and generalized arterio-sclerosis	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature R. F. Murray

Address 927 W. Monument St Date signed 5/22/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04654

Reg. Diat. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos.

Hospital, institution, or street address where death occurred: Gil Top School

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5407 Hampton Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Samuel Ross

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 28 1928

8. AGE:

Years	Months	Days	If less than one day
17	3	16	hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER

12. Name: William Warfield Ross

13. Birthplace: Texas

MOTHER

14. Maiden name: V. Elfleda Payne

15. Birthplace: Virginia

16. Informant: Mrs E. P. Ross

Address: 5407 Hampton Lane Bethesda Md

17. Burial, cremation, or removal. Which? removal Date thereof: May 14 1945 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location:

18. Funeral director: J.W.m Lee's Son Co

Address: 600-4-2. N.E. - D.C.

19. (Date rec'd by registrar) May 15 1945 Edna Hoelich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945 at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1944 to May 14 1945 and that I last saw h alive on May 14 1945

	DURATION
Immediate cause of death: Congenital malformation of heart	5 yrs.
Due to: Myocarditis	6 wks
Due to: Bacterial Infection	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Bethesda Md Date signed 5/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04655

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 years

Hospital, Institution, or street address where death occurred:
53 Calvert St. Annapolis Md.

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 53 Calvert St. Annapolis Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Walter Clarence Ross

3. (b) Social Security Number: 218- 07-814

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widower

6.(b) Name of husband or wife: Nancy Ross

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 1884

8. AGE: Years	Months	Days	If less than one day
60 60	6		..... hrs. ..... min.

9. Birthplace: Annapolis A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: None

FATHER
12. Name: John Ross
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Simms
15. Birthplace: A. A. Co. Md.

16. Informant: Charles Ross
Address: 53 Calvert St Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 / 29/45 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. May 29 19 45 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/25 19 45 at 12-10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1 19 45 to ..... 19 .....
and that I last saw him alive on 5/25/45 19 .....

Immediate cause of death	DURATION
Pulmonary Edema	1 day
Due to: Chronic Myocarditis	-
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hoche A Jansen M.D.
M. D. or other

Address: 25 Northwest Street Date signed 5/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-A)

CERTIFICATE OF DEATH

04656

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: 5430 Wasina Ave. Arundel Village, Balto 25 Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Virginia County: TUCKER
City or town: ST. GEORGE.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Garland F. Sampson

3.(b) Social Security Number: 236-12-9329

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: ICEY Sampson
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 1944

8. AGE: Years	Months	Days	If less than one day
3'	?	?	____ hrs. ____ min.

A

9. Birthplace: UNKNOWN (Town, county, and state)
10. Usual occupation: UNKNOWN
11. Industry or business: UNKNOWN
FATHER 12. Name: UNKNOWN
FATHER 13. Birthplace: UNKNOWN
MOTHER 14. Maiden name: UNKNOWN
MOTHER 15. Birthplace: UNKNOWN
16. Informant: Mineay Funeral Home
Address: Parsons W. Va
17. Ship (Burial, cremation, or removal. Which?) Date thereof May 15, 1945 (month) (day) (year)
Cemetery or crematory: Mineay Funeral Home
Location: Parsons, W. Va.
18. Funeral director: Thomas W. Duggleton
Address: Glen Burnie, Md.
19. May 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Sudden death due to asphyxia - caused by "burnt eliminating gas."	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident. Date of 5/12/45
Where did injury occur? Arundel Village (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: auto accident Injured at work?

23. SIGNATURE: Gustave H. Pardenkirk M. D. or other acting coroner
Address: Glen Burnie Md. Date signed 5/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bal)

CERTIFICATE OF DEATH

T 04657

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:
823 west St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 823 west St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah K. Schwallenberg

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: William F. Schwallenberg

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 26 1858

8. AGE: Years	Months	Days	If less than one day
87	1	26	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: William Shesbeck
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Wayson
15. Birthplace: Maryland

16. Informant: Mrs Minnie Kries
Address: 823 west St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7/45 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: B. L. Hopkins

18. Funeral director: Annapolis Md

Address:

19. May 5 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45 to May 4 19 45 and that I last saw h... alive on May 4 19 45

Immediate cause of death	DURATION
Acute Dilatation of the heart	5 minutes
Due to	
Due to	
Other conditions: Arteriosclerotic Cardio-Vascular disease	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson MD
M. D. or other

Address: Annapolis Md Date signed: 5/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

04658 T

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Severn, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Odenwald Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry E. Sherman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife Ethel I. Sherman
nee Upton 6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) January 2nd 1882

8. AGE: Years 63 | Months 2 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Chef
11. Industry or business Md State Police.

FATHER
12. Name George W. Sherman
13. Birthplace Baltimore, Md

MOTHER
14. Maiden name Sarah W. Gross
15. Birthplace Philadelphia

16. Informant Mrs. Harry E. Sherman
Address Severn, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof May 7-1945 (month) (day) (year)
Cemetery or crematory Glen Haven Mem
Location Glen Burnie, Md.
18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.

19. May 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 2.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
sudden death due to coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gustave A. Paulert M.D.
attending medical (or M. D.) or other
Address Glen Burnie Md. Date signed 5/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-7)

CERTIFICATE OF DEATH

13c T

04659

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years 2 months

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 5 years, 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: No home. Came from Balto. City

(If rural, give LOCATION) Hospital ✓

2.(a) If veteran, name war:

3.(a) FULL NAME

SMITH - ALICE

3.(b) Social Security Number

---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1860 ?

8. AGE: Years	Months	Days	If less than one day
85 ?	unknown		---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER

12. Name: Isiah Smith

13. Birthplace: Virginia

MOTHER

14. Maiden name: Frances ?

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 5-11-45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Balto, Co

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley ave

19. (Date rec'd by registrar) 5/8 45 E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 19 45 at 12:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 19 40 to May 8 19 45 and that I last saw her alive on May 8 19 45

Immediate cause of death	DURATION
General Arteriosclerosis - Chronic Myocarditis	Known to us since 3/8/40
Due to: ---	
Due to: ---	
Other conditions: Senile Psychosis (Include pregnancy within 3 months of death)	Known to us since 3/8/40

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D., or other

Address: Crownsville, Maryland Date signed: 5/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

B-04653

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Q. A.

City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 7 months 26 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 y. 5 m. 26 d.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 Pierce Street
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Smith, Roland

3.(b) Social Security Number

4. Sex	5. Color or race	(a) Single, married, widowed, or divorced
M	B	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
32			..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER — 12. Name Bill Smith

13. Birthplace

MOTHER — 14. Maiden name —

15. Birthplace —

16. Informant Hospital records

Address Crownsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 1945 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem.

Location Baltimore Md.

18. Funeral director Mrs. Katie Williams

Address 722 N. Broadway St

19. 5/20 1945 E. T. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945 at 4 38 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-23 1945 to 5-19 1945 and that I last saw him alive on 5-19 1945

Immediate cause of death	DURATION
Mil. Tbc.	once Oct. 13, -44
Due to	
Due to	
Other conditions Dementia Praecox	now -36

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Herbert A. Goodwin, M. D. or other

Address Crownsville Date signed 5-20-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

BCT 04660

Reg. Diat. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mohth, 22 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 month, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: --------

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 2615 Boone Street (If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: TUNSTALL - WILLIAM

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: --------

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 82 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER — 12. Name: Henry Tunstall; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Betty Easter; 15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof May 23, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Anne Arundel County

18. Funeral director: James A. Hayes

Address: 142 W. Hill, Baltimore, Md.

19. May 21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1945, at 12:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1945, to May 20 1945 and that I last saw him alive on May 20 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 3/28/45
Due to: ---------	
Due to: ---------	
Other conditions: Senile Psychosis	Known to us since 3/28/45

(Incinde pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: -------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of: ------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? ------

23. SIGNATURE: Mark V. Hinkaude M. D. or other

Address: Crownsville, Maryland Date signed: 5/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

T 04661

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Nd,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, Institution, or street address where death occurred:
104 Villa Ave. Smithville Annapolis Md.

How long in hospital or institution?: ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Smithville Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 104 Villa St.
(If rural, give LOCATION)

2.(a) If veteran, name war: * **********

3. (a) FULL NAME

Eva Alice Wallace

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Abraham Wallace

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): March 15, 1889

8. AGE: Years	Months	Days	If less than one day
56 56	1	19	..... hrs. ..... min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: None

FATHER
12. Name: Thomas Creek
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Mary Jones
15. Birthplace: A. A. Co. Md.

16. Informant: Mr Abraham Wallace

Address: 104 Villa Ave. Smithville Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1945 (month) (day) (year)

Cemetery or crematory: St. Mary,s Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. May 5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 45 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2/12 19 45 to 5/4/45 19 ..... and that I last saw h.. alive on 5/4/45 19 .....

	DURATION
Immediate cause of death: Cerebral Accident	
Due to: Hypertension	2 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Hendrie H. Johnson M. D
M. D. or other

Address: 35 Northwest Stall Date signed 5/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of approximate age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

04662

FILE G95 JUN 5 1945

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months & 13 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 4 months & 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rigga Ave. 1510
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John Walters

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Separated

6.(b) Name of husband or wife:

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years	Months	Days	If less than one day
38			...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: John Walters

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Emma Johnson

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/1/45 (month) (day) (year)

Cemetery or crematory: Arbutus

Location: Balto Co

18. Funeral director: Mr. Geo F. Holland

Address: 1631 Druid Hill Ave

19. May 29 1945 (Date rec'd by registrar) M. Lee Albaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1945, at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1945, to May 28, 1945 and that I last saw him alive on May 28, 1945

Immediate cause of death	General Paresis	DURATION: unknown
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert V. Donaldson, M. D. or other

Address: Crownsville, Md. Date signed: 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

T

04663 20

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Md

City or town Friendship

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Md County A A Co.

City or town Friendship

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Richard Francis Ward

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Agnes Ward

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1869

8. AGE: Years 75 | Months 8 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business .....

FATHER 12. Name John C Ward

13. Birthplace Md

MOTHER 14. Maiden name Jane Brady

15. Birthplace Md

16. Informant Walter Ward

Address Camp Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30-1945 (month) (day) (year)

Cemetery or crematory Friendship. Md

Location Friendship

18. Funeral director Harry K Talbert

Address Parkton. Md

19. 5/29 (Date rec'd by registrar) 19 45 W. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 19 45, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45, to May 28 19 45 and that I last saw him alive on May 27 19 45

	DURATION
Immediate cause of death Cerebral embolism	2 mi
Cerebral hemorrhage	5 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H M Ward M. D. or other

Address Emmitsburg Md Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

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T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1950)

04664

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. Geo. G. Meade, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred: Firing Range

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pennsylvania County: --

City or town: Erie (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #3, Zimmely Rd. (If rural, give LOCATION)

2.(a) If veteran, name war --

3. (a) FULL NAME Howard J. WEAVER, Jr., 33,917,646

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife --

6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept 18 1926

8. AGE: Years	Months	Days	If less than one day
18	7	28	- hrs. - min.

9. Birthplace: Conneaut Lake, Pa. (Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER

12. Name: Howard J. Weaver, Sr.

13. Birthplace: Unknown

MOTHER

14. Maiden name: Berneice (unknown) Weaver

15. Birthplace: Unknown

16. Informant: Service Record

Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 17 May 1945 (month) (day) (year)

Cemetery or crematory: Schaal Funeral Home

Location: 550 W. 9th St., Erie, Pa

Howard M Blight Jr

18. Funeral director: Howard Blight Jr

Address: 4914 Belair Rd. Baltimore, Md.

19. 17 May 1945 (Date rec'd by registrar) W J Lawson Jr. W. J. LAWSON, JR. MAC Registrar 1st Lt., MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 May 1945 at 1600 M

21. I CERTIFY that death occurred on the date above stated: that I xxxxxxxxxxx viewed deceased xxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxx 16 May 1945

Immediate cause of death: Wound, perforating right chest posterior with laceration of right lung, liver & heart. xxxx Multiple lacerations of scalp, neck, right thigh & right forearm.

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations --

Date of op. --

Autopsy results: Confirmed as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 16 May 1945

Where did injury occur? Ft. Meade, Anne Arundel, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Firing Range

Means of injury: Bazooka Explosion Injured at work? Yes

23. SIGNATURE [signature] M. D. or other

Address: Regional Hosp, Ft Meade, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04665

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: aa
City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: aa
City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Glenn Helen Webb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 2 1898

8. AGE: Years: 47 | Months: 2 | Days: 13 | If less than one day: ... hrs. ... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Manager

11. Industry or business: Tobacco house

FATHER
12. Name: Emit M. Webb
13. Birthplace: Md

MOTHER
14. Maiden name: Edith Routt
15. Birthplace: Md

16. Informant: Mrs. Kenneth Webb
Address: Jewell Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17-45 (month) (day) (year)

Cemetery or crematory: Friendship
Location: Friendship

18. Funeral director: W. H. Whitelus
Address: Olney Md

19. May 16 1945 H. R. Clayton Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945 at 1015 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1945 to May 15 1945
and that I last saw him alive on May 15 1945

Immediate cause of death	DURATION
Acute myocarditis	5 hrs.
Lobar Pneumonia	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Howard M. D. or other
Address: Olney Md Date signed May 16 45

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (464)

04666

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JULIA ETTA WEBSTER

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	w.	widow

6.(b) Name of husband or wife: Ganby Webster
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1892

8. AGE: Years	Months	Days	If less than one day
52	7	15	hrs. min.

9. Birthplace: Solomon's Island, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Wm. R. White
13. Birthplace: Princess Anne, Md.

MOTHER
14. Maiden name: Mary E. Price
15. Birthplace: Princess Anne, Md.

16. Informant: Thos. A. Webster
Address: Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-11-45 (mooth) (day) (year)
Cemetery or crematory: Glen Haven Mem. Park
Location: near Glen Burnie, Md.

18. Funeral director: John Taylor
Address: Annapolis, Md.

19. 5-8- 1945 L-A-Weir
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1945 at 7.00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-3 1943 to 5-8 1945
and that I last saw her alive on 5-3-45 19

Immediate cause of death	DURATION
General metastatic carcinomatosis	
Due to: Carcinoma of rectum	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L-A-Weir M.D.
M. D. or other
Address: Pasadena, Md. Date signed 5-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

T 04667

Reg. Dist. No. 2-1

1. PLACE OF DEATH:
County: A. A. County
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: A. A. Co.
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eva L. Wellener

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm F. Wellener
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	0	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William F. Mathenny
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Amanda Melvin
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Wm F. Wellener
Address: Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-1-45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18. Funeral director: Wm J. Tickner & Sons
Address: Baltimore, Md.

19. May 31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944, to May 29 1945
and that I last saw h-- alive on May 29 1945

	DURATION
Immediate cause of death: Carcinoma of the Lung	4 months
Due to: Carcinoma of the Breast	2 years.
Due to: Carcinoma of Humerus	18 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James S. Buckingham M.D.
M. D. or other
Address: Glen Burnie, Md. Date signed May 31, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G 9 4 MAY 16 1945

04668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 21.

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Green Haven adc. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Green Haven Pasadena Md. R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Horace White (WHITE)

3. (b) Social Security Number: 212-22-1109

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 16, 1887 1877

8. AGE: Years	Months	Days	If less than one day
67	9	17	..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Stationary Engineer

11. Industry or business: Canning Factories

FATHER — 12. Name: unknown
FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown
MOTHER — 15. Birthplace: unknown

16. Informant: Mrs. Keely
Address: Green Haven

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Anne Arundel Co. Md

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie Md.

19. 5-3 1945 L.A. O'Neil
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1945 to May 3 1945
and that I last saw him alive on May 2 1945

Immediate cause of death	DURATION
Decompensated heart disease	2
Due to: Bronchial infection	
Due to:	
Other conditions: Chronic nephritis Diabetes mellitus	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L.A. O'Neil M.D.
M. D. or other
Address: Pasadena Md Date signed 5-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 04669 T

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 7 mos., 5 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 yrs, 7 mos, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1109 West Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: WILLIAMS - GEORGIANA

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years: 75 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: Fred Hinds
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Anna Davis
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: May 14, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Maryland

18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St., Balto, Md.

19. May 10 1945 (Date rec'd by registrar) E-7 Joyce Local Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: May 10 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1938, to May 10 1945 and that I last saw her alive on May 10 1945

Immediate cause of death	DURATION
Apoplexy	
Due to: Hypertension	
Due to: ---	
Other conditions: Old Schizophrenia	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 5/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04670 T

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 years

Hospital, institution, or street address where death occurred:
825 Spa. Rd. Annapolis Md.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 825 Spa. Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: **********

3.(a) FULL NAME: Annie Wright

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: **********

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): February 1889

8. AGE: Years	Months	Days	If less than one day
56	2		...hrs. ...min.

9. Birthplace: Mt. Zion A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr Matthew Wright

Address: 825 Spa. Rd. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1945 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. May 3, 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945, at 12:20P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 1945 to May 2, 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Theodore J. Abrem M.D. M. D. or other

Address: 35 Northwest State Date signed: 5/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15